BULLETIN

OF THE

SOUTH INDIAN MEDICAL ASSOCIATION.

NOVEMBER 1933.

Major-General C. A. Sprawson.

Whilst congratulating Major-General C. A. Sprawson, C.I.E., K.H.P., I.M.S., on his well deserved promotion, we regret very much he has had to leave us on his appointment as the Director-General of the Indian Medical Service. A brilliant clinician, an able administrator, General Sprawson belongs to that small band who possesses the broadness of vision to realise that the medical relief of the country depends more on the satisfactory basis in which the independent medical profession is placed rather than pampering to the wishes of the services.

He has been able during his tenure not only to satisfy the just demands of the services placed under his care but also to further the aims initiated by the Union and increase the professional opportunities for the independent practitioner. A further expansion of the honorary scheme, improvement in medical education, increase in the standards of education of the medical schools whose alumni form the majority of the general practitioners, his regime has been marked by distinct progress in the fields of medical relief and medical education. The popularity and esteem in which he was held by the profession in this presidency was demonstrated at the farewell party given by the Union to him—the first occasion when the *Independent* medical profession solidly gathered to do honour to a *Service* chief.

We wish General Sprawson a happy and useful period of service in his new sphere and trust that, though far away, he will continue to evince that regard for the welfare of the independent medical profession in this presidency that he did when here.

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Beware the Greeks Bearing Gifts.

The popular mind is always fascinated by the unknown and the mysterious. The pharmaceutical chemists and the patent drug manufacturers have not been slow to exploit this human trait. Innumerable nostrums and universal panaceas have long been flooding the drug stores of western countries. The havoc had grown to such proportions that countries like the United States of America have begun to take measures to combat this evil. But India has a vast population and great amount of sickness. Here medical men are not always available and the people are generally too poor to consult them when available. As such this country offers an admirable field for these drug makers. We were therefore glad when our public men interested themselves in this question in the Legislative Assembly. The Drugs Enquiry Committee was appointed as a result. We have not seen its report, nor are we aware of the action which the Government has taken on the report.

The prevention of the exploitation of its citizens by worthless and inferior drugs is eminently a duty of the State. But when the State delays to make up its mind, some means should be found for the performance of this function. In countries where the profession is efficiently organized, medical associations carry on intensive work to educate the profession and the public about the merits and defects of vaunted remedies. And in this task, they are ably supported by their Governments. In this country we suffer from many disadvantages. Well equipped non-official laboratories are almost non-existent. The chemical industry is just being born. The pharmaceutical manufacturers are in their early infancy. The profession itself is unorganized, and the idea of organizing itself for useful work has hardly suggested itself to it. In these circumstances, the scope for the drug manufacturers is unlimited and all sorts of expensive trash are dumped into this land without any hindrance.

We do not propose here to enter into details about the methods of this drug sale. Our readers are well familiar with them. But the individual members of the profession may not know the immensity of this danger. Ever since the profession began to lay emphasis on the dangers of oral sepsis the manufacturers have been placing on the market an increasing number of tooth pastes and "antiseptic" mouth washes. These are usually elegantly coloured and pleasantly scented. They are generally put up in attractive bottles with appealing labels. It is often claimed for them that they kill bacteria, and to give an air of scientific accuracy, the number of organisms killed by the product in a particular time limit is published They claim to prevent pyorrhoea alveolaris. The public is generally impressed by these statements. And some medical men prescribe them to their patients, and this, in spite of the fact that well documented findings have been published by a reputed medical journal denying antiseptic properties when used as diluted mouth washes and

gargles. It has been calculated that a commonly sold antiseptic product costs four hundred and ninety-five dollars to do the service of a cent worth of corrosive sublimate, or fifteen dollars worth of it equals a cent worth of phenol in antiseptic effect.

This propaganda for sale of drugs has become more aggressive in recent years. The manufacturers are not content with advertising in the newspapers and some medical journals. They have been flooding medical men even in remote villages with packets and bundles of advertisement literature. Various agents travel about with big boxes, distributing literature and almost forcing their samples on medical men. And almost every mail brings basketfuls of free samples and coupons for more The current fads are carefully studied and a large number of drugs and their variants which may have the remotest association with such diseases are lauded under a bewildering variety of names. At the present moment specifics for anaemias, cures for vitamin deficiency and calcium defective states, gland products and tonics are the vogue. The pharmacologist and the physician might say from the house-tops that liver therapy is only useful in particular types of anaemias, but the multitude of manufacturers will advertise everywhere that liver products are indicated in all anaemias. The question of calcium metabolism might still puzzle the researchers all over the world, but the manufacturer already sings the praises of his particular calcium product for use in all sorts and conditions of ill health and even in health. It is well known that most gland products are not useful when taken by mouth. But almost every manufacturer has evolved some process by which his preparations are said to be potent when taken by mouth. They are already putting up "tonics" which are said to contain active gland products. We should not be surprised if most of them are merely sweetened spirits with subminimal quantities of some inoffensive drugs or other products.

A consideration of these various drugs would make a diverting study in "bottled phychotherapy." But our object is merely to draw the attention of our readers to the real danger of allowing these firms and their agents to crowd the tables of medical men with free samples given with such apparent generosity. The success of their advertisements has so increased the audacity of these people that from hoodwinking the public they are now bent on taking in medical men. The medical man generally starts with scepticism, but often succumbs to the repeated suggestions of the agents, and indirectly helps the sale of these drugs till after a few months he realizes their worthlessness. But in the meanwhile, the mischief has been done and it gathers momentum from mouth to mouth of the patent drug habitues and we are ashamed to say, of the prescribers.

We trust that our readers are convinced that the menace of the patent drug is real and that the poor of this country are made to buy generally worthless drugs at tall prices. We have already said that the State should exert itself to put this down. But in its absence, the profession should create an organization which could diffuse information about the relative value of patent and proprietary drugs and their equals and betters in the official pharmcopœa. We therefore welcome the move among the officers of the Union for the formation of a Council which would freely and willingly supply to its members all available information on the therapeutic value of proprietary and secret drugs.

The Medical Council Bill.

The Indian Medical Council Bill as amended by the Select Committee would be taken up for consideration in the Legislative Assembly next week. The Report of the Select Committee states that the Bill has not been so altered as to require republication. This remark should ordinarily lead the public to believe that even the more objectionable features of the measure against which protests have been made ever since the publication of the Bill last year, have not been attempted to be removed or modified. It is gratifying to note, however, that the changes effected are in the direction of distinctly improving the Bill. Licentiates in Medicine have from the first been demanding that if an All-India Register is maintained, they should have a place in it. The Select Committee, in partial recognition of the force of this objection, have decided that there should be no All-India Register, because the existence of two Registers would lead to unnecessary duplication and complication and otherwise result in double appeals in disciplinary matters. The Bill therefore has been designed with a view to securing two objects, *viz.*, the maintenance of a uniform register of qualifications in medicine for all provinces ; and the arrangement of schemes of reciprocity with medical authorities in other countries. So far as the Indian Medical Council is concerned, it is worthy of note that the President would be nominated for the first four years by the Governor-General-in-Council, and that that officer would be elected thereafter by the members of the Council from among themselves. Objection had been taken to the provision that the medical faculties of British Indian Universities should have representation on the Council. The Select Committee have altered this provision ensuring that each British Indian University should have a representative elected by the whole of the senate, though candidates for election should only be from members of the medical faculties who had had five years' experience in the teaching of medicine. As regards the omission of the Patna, Rangoon and the Andra Universities, they had been omitted from the first schedule, because, according to the Select Committee, their medical institutions had not been inspected before the preparation of the Bill. We are glad to note that the Select Committee state that this position is most unsatisfactory and have recommended the removal of this anomaly to the Council, one of whose duties as soon as it comes into being would be to secure the inclusion of all suitable qualifications granted to these universities. Each Provincial Medical Council, it was provided in the Bill, might send a representative to the Medical Council. This method of indirect election had now been set aside in preference to the method of direct election according to which all graduate members of any Provincial Register may elect one of their members to the Council. We do not at all see why the right should extend to only graduate members. The Select Committee claim that they have now provided for a wider electorate, but at the same time they recommend this restrictive provision. The right should extend to all members who are on the provincial registers. The Bill proposed that all medical qualifications granted in the United Kingdom, in the British Possessions and in certain foreign countries should be recognised in India for all time and without reference to the willingness of these countries to enter into any reciprocity arrangement. Very important modifications have been made by the Select Committee in the scheme, which is very properly described as being too loose. The statutory recognition of these foreign degrees, according to the

Report of the Select Committee, would be granted only for four years and thereafter any qualification which has not been covered by an approved scheme of reciprocity would automatically be removed from the Register. It is expected that during this period of four years, the Council would enter into negotiation with the medical authorities of other countries concerned in order to effect an agreement regarding schemes of reciprocity and if the negotiations fail, the operation of the clause in so far as those countries between which and India no reciprocity agreement is entered into, are concerned, will automatically cease.
—*Hindu, September 9th, 1933.*

Baroda Medical Registration Act.

In view of the fact that some medical practitioners though not educated in the medical science are carrying on the profession as medical practitioners and that in the interest and welfare of the public it is not advisable to allow such a state of things to continue, the Government of His Highness has enacted a Medical Act permitting only those persons who possessed the necessary qualifications to practise and get their names registered. The Act has been framed on the basis of the Bombay Medical Act with modifications suited to local conditions and after it was passed by the State Legislative Assembly at its previous sessions, was submitted to His Highness the Maharaja for sanction. The Act as approved by the Huzur has now been published in the latest issue of the State gazette over the signature of the legal Remembrancer for the information of the public.

It is provided that the Act shall come into force on December 12th this year and shall for the present apply to the City of Baroda only but could be extended to other parts of the state with the sanction of His Highness. A medical council will be established.

Working of Mental Hospitals.

INCREASE IN POPULATION

The following Government order has been issued on the report of the three Mental Hospitals at Madras, Calicut and Waltair for the year 1932 :—

The population of the three hospitals and their daily average strength continued to increase during the year as shown below :—

Year.		Total population.	Daily average strength.
1930	...	1,942	1,404
1931	...	2,077	1,500
1932	...	2,147	1,560

The Mental Hospital at Madras was responsible, as may be expected, for the largest population, 1,573, while Calicut and Waltair had a population of 413 and 161, respectively.

With a view to relieve the overcrowding in the Mental Hospital, Madras, patients other than criminal insanes from the district of Madura, Ramnad, Salem and Tinnevelly are admitted into the Mental Hospital, Calicut, and those from Chittoor are sent to the Waltair Mental Hospital. As even this arrangement does not seem to have had the desired effect proposals are now under consideration to extend the Mental Hospital at Madras, or to open a new Mental Hospital at Tanjore by utilizing the buildings of the Medical School Hostel.

The death-rate rose from 5·8 in 1931 to 6·6 in the year under review. The daily average number of patient sick

in the hospitals stood at 242 as against 233 in the previous year. Except for a few cases of influenza of a mild type at Madras and Calicut there were no epidemics worth mentioning.

Financial stringency continued to stand in the way of progress but normal activities were carried on as usual.

L. S. G. G.O. No. M. S. 1088 P. H., dated 19th May 1933.

The following rule will be substituted for rule 16-A of the rules relating to the appointment of Honorary Medical Officers in Government Hospitals in the Madras Presidency appended to G. O. No. 1610 P. H., dated 29th July 1932.

" 16-A. Honorary Medical Officers appointed to Government Hospitals where there is only one Government Medical Officer will be responsible for the conduct of post-mortem and other medico-legal work during the unavoidable absence of the Government Medical Officer but not in other circumstances. Honorary Medical Officers appointed to hospitals which are in charge of a Civil Assistant Surgeon with a lady doctor under him will be entrusted with post-mortem and other medico legal work during the unavoidable absence of the Civil Assistant Surgeon, the post-mortem examination of female bodies being however done by the lady doctor. The remuneration to be paid to the Honorary Medical Officers for the work will be regulated by paragraph 291 (2) of the Civil Medical Code ".

APPOINTMENTS.

Dr. P. Natesan, Hony. Assistant Surgeon, Government Royapuram Hospital.

Mr. V. Govindarajalu, Hony. Assistant Physician, Royapuram Hospital.

Dr. E. C. Srinivasan, Hony. Clinical Assistant (Opthalmic), Royapettah Hospital.

MEDICO-LEGAL.

Sale of Unlicensed Drug

CASE AGAINST A DOCTOR.

Mr. T. R. Sankaranarayana Aiyar, a registered medical practitioner of Kuttipuram, and Choyi, a qualified compounder, stood charged before the Stationary Magistrate, Badagara, with an offence under Section 8 (1) *(a)* read with Section 14 of the Dangerous Drugs Act of 1930, for unlicensed possession and sale of tincture opii.

The Magistrate found that under the rules framed under the Act, a registered medical practitioner could possess 120 grains of morpine for his own use. But he was prohibited from selling it without licence. As regards the contention that the prescribing of tincture opii did not tantamount to sale, the Magistrate found that under the rules, prescribing itself amounted to sale. The prescribing and the compounder issuing it on receipt of money clearly constituted sale. Both the accused were therefore found guilty. The Magistrate, however, held that the accused appeared to have committed the offence out of ignorance. The licence to possess or sell the drug was issued free of cost and such a licence they failed to take out. In the result, the doctor and the compounder were sentenced to pay a fine of Rs. 15 each or in default to suffer two weeks rigorous.

Against his conviction, the doctor has filed an appeal before the Sub-Divisional Magistrate, Calicut, on the 22nd instant.

Assesors' Fine set aside.

Mr. Justice Broomfiled and Mr. Justice Divatia at the Bombay High Court set aside the fine of Rs. 50 imposed by the Sessions Judge of Nadiad on Kashibhai Lakhabhai Patel for not complying with summons to attend the Court as an assessor.

Two days before the case for which he was called, the petitioner wrote to the Court explaining that he would not be able to attend as he was suffering from piles, fistula and dysentery. The petitioner also submitted the certificate of Dr. Talati.

The Court, however, directed that the petitioner should be examined by the Police Surgeon. The latter reported that though the petitioner was suffering from the above-mentioned complaints the illness was not so serious as to prevent his attendance in Court. The Court, thereupon, directed the petitioner to attend the Court. On his failure to do so, the Sessions Judge fined him Rs. 50, and directed him to pay the fees of the Police Surgeon for examining him.

JUDGMENT

In setting aside the fine, the judges observed that both doctors were agreed that the petitioner was suffering from certain complaints, and Dr. Talati, a qualified practitioner, had testified that he was not in a fit condition to attend. In view of this, the Sessions Judge should have exempted the petitioner, from attendance, and called him for the next sitting of the Court.

Their Lordships set aside the Sessions Judge's order.

Mr. N. P. Desai appeared for the petitioner and Mr. B. G. Rao, Government Pleader, for the Crown.

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Fees for Attendance on Near Relatives.

In recent case of Fielding—Ould *v.* Ould, a medical practitioner claimed £ 650 for medical attendance upon his mother. He said that during the six years before her death he had attended her professionally 299 times. Her executors, resisting the claim, contended that there had been no agreement that he should be paid. Claims for medical fees are based on a contract *or implied*, it being *assumed* that patient who receives medical treatment undertakes to pay a reasonable sum in return even if nothing is said. A son, however, might attend to his mother without an eye to fees. The executors alleged that many of the visits for which the plaintiff was charging were of a filial and social rather than a professional nature. The plaintiff on the other hand, said that his mother had promised that he should be paid ; he also called witnesses who had heard the mother say her son should be paid. She was an old lady of 94 who would have no other doctor ; she seems to have sent for him frequently and he had considerable distance to travel. Mr. Justice Swift came to the conclusion that the plaintiff was entitled to be paid and that his charges were reasonable.

There is, it seems, no rule of professional etiquette preventing a doctor from charging for attendance on a near relative. Evidence was given on the plaintiff's behalf by a medical practitioner to establish that there was no such rule. This evidence not rebutted by the defendants and was accepted by the Judge. The decision depended, of course, on the particular facts of the case. There was here a contract though there may be many other cases where a son attends his mother without any intention of charging for his services and therefore without any contract.

South Indian Medical Union

[The General Secretary invites suggestions and designs from readers for an Emblem for the Union.]

1. The Council of the Union met at 32, Broadway, on Monday the 7th August 1933 at 6-30 p.m., with Dr. E. V. Srinivasan, Vice-President, in the chair, to consider the work before the Union for the year 1933-34.

It was the general opinion that the membership of the Union should be improved, and that the activities of the Union might be made more attractive so as to draw more members of the independent medical profession into it. It was suggested that more social and clinical meeting should be organised than hitherto.

The General Secretary suggested, and the Council accepted, that an emblem of the Union, as was provided in the bye-laws, should be introduced at an early date, and that designs for such an emblem might be asked for.

2. On Tuesday the 22nd August 1933, a meeting of the Publicity Section was held at 89, Poonamallee High Road, Kilpauk, with Dr. U. Rama Rao in the chair, to consider the resignation of Dr. M. Subramania Iyer, Publicity Officer, from the Publicity Section, and to appoint a member to take charge of the Advertisement Department of the Bulletin in the place of Dr K. P. Rama Hebbar, who had resigned and whose resignation had been accepted.

The letter from Dr. Subramania Iyer was read, and his resignation was accepted. The General Secretary was instructed to infrom Dr. Subramania Iyer of this, and to thank him on behalf of the Publicity Section and of the Union for the services he had rendered during his term of office. Dr. T. Krishna Menon was recommended to be appointed in the place of Dr. Subramania Iyer, and also for looking after the Advertisement Department.

3. On Thursday, the 24th August 1933, a Social was held at 32, Broadway. More than 50 members were present. After tea, Dr. S. Rangachari, the president of the Union, addressed the members on his recent experiences in Europe, wherefrom he had returned but shortly. The function was a great success, and the thanks of the Union are to be recorded here to the member, who (though he prefers to remain anonymous), by defraying the expenses, made the Social possible.

4. The Council of the Union met in September on Monday the 4th at 6-30 p.m., at 32, Broadway, with Dr. E. V. Srinivasan in the chair. The recommendations of the Publicity Section which were placed before the Council by the General Secretary, were accepted. The following gentlemen were admitted to membership after consideration of their applications :—

Dr. J. A. S. Masilamoni, M. B. B. S. (Madras, 1929), 9, West Mada Church Road, Royapuram.

Dr. T. R. Ramanathan, B A, M B. B.S. (Madras, 1932), 286, Lingha Chetty Street, G. T., Madras.

Dr. L. V. Srinivasan, M. B. B. S. (Madras, 1928), 98, Big Street, Triplicane.

Dr. V. D. Gopal Rao moved :

" That while the South Indian Medical Union records its thanks to the Government of Madras for their forward policy in levelling up the standard of medical education in the Presidency by raising the L.M.P. course to five years, it is of the opinion that the preliminary educational quali-

fication should be raised to the Intermediate or other equivalent standard of a University, in order to achieve the aims with which the L. M. P. course has been extended."

Dr. T. Krishna Menon seconded the resolution, which was carried unanimously. The Secretaries were instructed to forward it to the proper authorities.

5. During the month of September 1933, three clinical meetings of the Union were held at 32, Broadway.

The first was on the 11th, with Dr. U. Ramo in the chair. Lt.-Col. V. Mahadevan, F. R. C. S., M R. C. P., I. M. S, Lecturer in Surgery, Government Royapurm Medical School, gave a lecture on "The Treatment of Burns" before a large audience of medical men and students.

The second took place on the 18th; Dr. K. P. Bhujanga Rao occupying the chair, and Dr. P Rama Rao, D. M. R. (Vienna), reading a paper on "X-Ray Evidences of Pathological Appendix".

The third was held on the 25th; Dr. P. Govinda Rao, M. B., B. S., reading a paper on "Sacral Anaesthesia", with Dr. E. V. Srinivasan presiding.

6. A meeting of the Council was held at 32, Broadway, on the 2nd October 1933 with Dr. E. V Srinivasan in the chair.

Dr. P. S. Kuppuswamy, M B. B.S., of 1/136, Broadway, Madras, was elected to membership of the Union.

At this meeting the General Secretary suggested that Major-General C. A. Sprawson, C. I. E., K. H S., I. M. S, who was shortly leaving Madras, should be entertained by the Union to tea, in token of the deep interest he had taken in the welfare of the independent medical profession in Southern India, and it was agreed to by the members present that a subscription tea should be arranged for, and General Sprawson invited to it before he left for New Delhi to take up his duties as Director General of the Medical Services.

7. As was decided at the meeting of the Council held on October 2nd, Major General C. A. Sprawson was entertained at tea at the Madras Medical College Grounds on Saturday, the 7th October 1933 at 5 p.m. A large number of members attended. Among the other guests were Mr. S. Muthia Mudaliar, Ex-Minister, Mr. S. Sengodiayan, I.C.S., Lt.-Col. V. Mahadevan, I. M. S., Dr. V. Rama Kamath, and Dr. P. K. Warrier.

After tea, Dr. Rangachari took the Surgeon General round and introduced him to all the members present; and in a short speech he dwelt on the services General Sprawson had rendered to the independent medical faternity in Southern India during his term of office as Surgeon-General in this Presidency. He congratulated Major-General Sprawson on his well-deserved promotion.

General Sprawson, replying, said that he was pleased and gratified to meet the members of the South Indian Medical Union, the names of many of whom were familiar to him though their faces were not; that in doing for the Independent Medical Profession what he did he was doing only his duty; and that he would consider it a privilege to be of service to the doctors in this country, whether they belonged to the services or not.

The Secretaries record here with pleasure their thanks to the Principal of the Madras Medical College for having allowed them the use of the

College premises for holding the function.

8. On October the 9th, a clinical meeting was held at 32, Bioadway, with Dr. T. Satakopan in the chair, when Dr. V. Govindarajulu, M. B B S., read a paper on "The Dysenteries: their Diagnosis and Treatment".

On the 23rd October another clinical meeting was held at the Bryson School, Government Royapuram Hospital, when Dr. T. Krishna Menon gave a lecture on "The Principles of Electrocardiography". The meeting was very well attended by medical men and students; a large number of lady students and men students having specially come to listen to the Lecturer. Dr. R. R. Williams, Lecturer in Medicine, Government Royapuram Medical School, who had kindly consented to preside was unable to do so on account of ill-health, and Dr. M. L. Kamath, Superintendent, Government Royapettah Hospital, kindly took the chair.

The lecture was illustrated by many instructive lantern slides, and was a very lucid exposition of a very difficult subject.

The Secretaries record here their thanks to the Authorities of the Government Royapuram Hospital for having allowed the use of the Bryson School for this lecture.

OTHER ASSOCIATIONS.

North Arcot Medical Association.

A meeting of the North Arcot District Medical Association was held, on 12th September at 5-15 p. m., in the Hospital Bangalow, Thottapalayam, when Miss C. E. Jameson, M.D., read a very interesting paper on "Results in Bacteriophage treatment of bacillary dysentery", with Dr. A. Degensing in the chair. Dr. Helen Jesudason gave a practical demonstration, at her laboratory, on the preparation of phage.

A meeting of the North Arcot District Medical Association was held, on 18th October in the Mission Hospital at Thotapalayam, with Miss M. P. Jefferys, M.A., M D., in the chair. Mr. John Scudder, B SC, M D., read a paper on "The history of cancer and new formulation of radium therapy," in the course of which he dealt with the antiquity, evolution, etiology, newer aspects and treatment of cancer by practical demonstration on three patients under his treatment at Ranipet. The meeting was attended by a large number of medical practitioners and medical students.

South Arcot Medical Association.

The annual meeting of the S. Arcot District Medical Association was held in the Government Headquarters hospital. About 60 medical men from all over the district were present. Dr. J. J. Joseph, special leprosy officer, gave a lecture on "Leprosy and how to control it" illustrated by lantern slides. Dr. Kamath, District Medical Officer, presided. The annual dinner was held the same night at the "Ganapathi Vilās".

Chettinad Medical Association.

Under the presidentship of Mr. N. C. Appaya, the Chettinad Medical Association held its monthly meeting at the S. M. S. High School, Karaikudi, when Dr. S. T. Achar, M.D., Physician, Tanjore Medical School, delivered an interesting lecture on "Some recent advances in Medicine." A lively discussion followed on the modern treatment of diseases like diabetes, tuberculosis and gastric ulcers

in which the members took part. After a vote of thanks from Mr. T. S. Shetty, the Secretary, the meeting came to a close.

East Godavari Medical Association.

A meeting of the East Godavari District Medical Association was held at Cocanada, on the 9th September. 60 members from all over the district attended the meeting which was held in the District Board Meeting Hall preceded by a tea-party given by the local doctors to their brethren from the district. Major T. S. Shastry, I.M.S., the President, presided over the meeting. A number of interesting cases from the Cocanada Headquarters Hospital including a "Haematoma" Axilla—pyaemic—and an aneurysm of the thorax—were exhibited. Papers were read by Dr. V. N. Benegal on "Rickets", Dr. S. L. Somayajulu on a "Successful Diabetic", and Dr. B. Emberumal on "A Dysenteric Child." Dr. T. Lakshminarayana, District Health Officer, referred to the importance of a tuberculosis campaign in the district and exhorted the audience to help him in the various ways which he outlined. The rules of the association were put up for discussion and passed *nem-con.*

There was a dinner at 9 a.m., after which the gathering dispersed.

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The monthly meeting of the East Godavari District Medical Association was held at Pithapuram on the 14th instant at 4 p.m. Major T. S. Shastry, I.M.S., presided.

After the exhibition of cases of Empyema and tubercular knee Dr. K. V. Ramachandramurti of Pithapuram read a paper on "Trachoma." Dr. Kanagaraju supplemented him saying that puncturing the granules with a needle dipped in chaulmoogra oil after previous cocaination of the eye, and use of phenolaine as supplied by Smith Stannistreet, in corneal ulceration following on Trachoma were valuable measures worth trying.

Dr. Swami Naidu of Rajahmundry, who should have read a paper on "Some Difficulties in Private Practice" having been unavoidably absent, his paper was read on his behalf by Dr. T. Kanakarajn of Ramachandrapuram, Dr. Naidu complained of underselling by doctors by making operations cheap, and appealed to the Association to do something in the matter. Several others took part in the discussion in the course of which reference was made to certain evils—such as employment of touts, playing on communal feelings, underselling by doctors, etc., and it was pointed out that it would be a good thing if some solution were found by the Association. It was pointed out by one of those present that they would be placing themselves in a ludicrous position if resolutions were to be passed by the Association, stipulating that there should be no underselling, no canvassing by touts, no taking small fees for big operations, and so on and that since the doctor who resorted to such practices to gain work was bound to fall low in course of time no resolutions need be passed. With regard to the question of scale of fees for operations, or medical attendance, it was stated that breaches of etiquette according to the rules of the Medical Council as they were existing now, being framed in imitation of English customs and being unsuitable to conditions in India and to Indian manners and customs, were bound to be ignored by some members of the profession. The only thing that could be done under the circumstances, it was urged, was to hope that matters would be set right, in course of time merely by virtue of the personal contact in the fellowship evolved through the active

working of the Medical Association where each one would during the monthly contact develop a sense of genuine affection and not hypocrisy for each other—which would thereby eventually result in each member being ashamed to do any of the acts complained of.

Major Shastri in winding up the debate said that there was no use of resolutions in the matter and that he looked forward to the Association and the personal contact evolved in it to remedy the state of affairs.

With a dinner party in the night, the members dispersed.

West Godavari Medical Association.

The third meeting of the West Godavari District Medical Association, was held on 10th September at 2 p m. at Bhimavaram under the presidency of Dr. J. Sivaram, Civil Assistant Surgeon Tanuku, when the District Medical Officer, Mr. S. Srinivasa Rao, read an instructive paper on "Fevers." The question of the constitution was postponed to the next meeting which was invited to be held at Tanuku early in November.

The doctors that attended the meeting were entertained at dinner, tea and supper by the Bhimavaram Taluk Medical Association.

The same night, the medical practitioners in the district put on boards "Rasaputra Viziam" in aid of the District Leprosy Relief Fund under the patronage of the Bhimavaram Revenue Divisional Officer, Mr. V. Hanumantha Rao Naidu.

Nearly Rs. 700 was collected, out of which two-thirds will be given to Tadepalligudem Leprosy Clinic and the balance to the Bhimavaram clinic.

Madura Medical Association.

A special meeting of the Madura Medical Association was held at the Government Headquarters Hospital, Dr. C. R. Kamath, D.M.O., and President of the Association, presiding. A condolence resolution on the sudden demise of Dr. M. Anantan Nair was moved from the chair and passed unanimously.

Nellore District Medical Association.

A monthly meeting of the Nellore District Medical Association was held on 19th August evening at the Government Headquarters Hospital. Mr. K. Krishna Rao, M.B C.M., District Medical Officer, presided. Dr. M. Moses, M.D., of the American Baptist Hospital read a paper on the preventible diseases of women.

Salem District Medical Association.

A meeting of the above association was held in the premises of the D. M.O.'s office, under the presidency of Lt.-Col. N K. Bal, District Medical Officer, Salem, when a large number of medical men were present.

Dr. S. Kanthimathinathan of the Government Hospital, Salem, read a paper on "The suggestive Therapeutics". Dr. Miss A. D'Cruz, Lady Assistant Surgeon of the Women's Hospital, Salem, was "at home" to all the members of the association.

The function terminated after Dr. K. Ramanatha Aiyar, L.M. and S., Secretary, had proposed a vote of thanks.

Trichinopoly District Medical Association.

A monthly meeting of the above Association was held at 4 p. m., on Saturday the 14th October 1933, in

the premises of the Trichy Medical Union, Ltd., China Bazar, Trichinopoly, when about 40 doctors were present.

The Directors of the above Union were "At Home" to the members.

Dr. P. A. S. Raghávan, the Secretary of the Association, proposed, Dr. T. V. S. Sastry to the chair.

Dr. T. S. S. Rajan welcomed the members to the Union and solicited their co-operation in furthering the Union which had in view the opening of an Ante-Natal Clinic, a Circulating Library and a Research Laboratory,

After reading the minutes of the last monthly meeting by the Secretary, Dr. R. Kalamegham, B.A., M.B., B.S., read an interesting paper on "Rhinitis" which was followed by a discussion.

With the concluding remarks from the chair and a vote of thanks to the hosts, Lecturer and the Chairman, the meeting terminated.

* * *

A monthly meeting of the above Association was held at 5 p.m. on Saturday the 23rd inst. in the Methodist Mission Compound, Woriur, Trichinopoly. About 45 doctors were present. Mrs. W. A. Sandford was "At Home".

Dr. R. Sambasivan welcomed Lt.-Col. N. M. Mehta back to the District and to the Association of which he was one of the founders, 4 years back. Lt.-Col. Mehta thanked the members for the welcome and promised his whole-hearted support for the Association.

There was an interesting discussion on the Leprosy Clinics in the various parts of the District and about half a dozen doctors gave their experiences in conducting the same.

With the reading of the minutes of the last meeting and with a vote of thanks proposed by Dr. Raghavan the Secretary the meeting terminated.

SOUTH CANARA DISTRICT MEDICAL ASSOCIATION.

Report for the year ending 30-6-1933.

The third year of existence of the Association has finished. The work during the year was quiet and steady. The notable feature during the year was the formal inaguration of the Udipi Branch of the Association, on 30-4-33, comprising of practitioners from the Coondapoor Revenue Division, *viz.*, the taluks of Karkal, Udipi and Coondapoor.

Membership:—The year opened with a total membership of 44 on the rolls, of which 23 were resident and 21 non-resident. During the year there were 4 resignations and 4 new admissions, among resident members, and one non-resident member. Thus the total number on rolls were 43 at the end of the year, 23 resident and 20 non-resident, totalling 43. Now that the Udipi Branch has been opened, it is hoped that all the practitioners in that area will join the Association and increase the membership.

Finance:—The usual membership fee of Re. 1-0-0 per month for resident members and Rs. 2 0-0 per half year for non-resident members was collected. Out of a total demand of Rs. 464-0-0, including the last year's arrears Rs. 319-0-0, were collected, leaving arrears of Rs. 145-0-0, excluding the amounts written off. The total receipt for the year including last year's opening balance of Rs. 191-10 9, come to Rs. 545-0-3, and expenditure to Rs. 309-5-3, leaving a balance of

Rs. 235-15-0. Out of this a sum of Rs. 150-14-5, has been invested under bye-law No. 7, being the entrance fee, donations, interests from general funds. It is hoped that all the outstandings will be collected soon The audited statement of accounts will be found in appendix I.

Owing to the formation of the Udipi Branch of the Association, a large number of non resident members will be transferred there. Hence the finance will be affected in the coming year.

Meetings :—There were 14 meetings during the year under report including the Annual General meeting as shown in appendix II. The thirteen meetings were clinical. The Association was fortunate in having two distinguished members of the profession, Dr. P. Rama Rao and Dr. M. L. Kamath, B.A., M.D., in addressing the members. The former came specially from Madras to give a magic lantern lecture. The latter's presence is availed by the members to address them. The committee offers its thanks to the lecturers at the clinical meetings. A new feature was introduced by our superintendent of Headquarters Hospital is the demonstration of cases from the wards at our clinical meetings.

Management:—The Executive Committee was re-elected at the annual meeting unanimously with the same office bearers. Dr. K. Giridhar Rao resigned his office in the latter part of the year, and Dr. B G. Acharya was elected in his place. The Executive Committee met five times during the year to transact business.

Journals :—During the year following journals were got for the Association :

1. British Medical Journal (weekly).
2. The Post Graduate Medical Journal (monthly).
3. The Practitioner (mohthly).
4. The Medical Practitioner (monthly).
5. Indian Medical Gazette (monthly)
6. The Medical Annual

The journals have been circulated locally. Some non-resident members have themselves arranged for getting the journals. In future the Udipi Branch will circulate amongst its members.

Member's Activities:—Two members of the Association, *viz*, the Drs. K. Vittal Shetty and P. G. Acharya were elected to the District Board. Dr. C. Manjunath Pai was elected to the Kasargod Taluk Board. The Association takes this opportunity to congratulating them at their success at the polls. The presence of these members on the respective boards will be of great advantage to their administration.

Habitation :—The Association offers its thanks to the Government of Madras for kindly allowing them the use of the Headquarters Hospital and Lady Goschen Hospital for the activities of the Association. It is with great pleasure that we regard our grateful thanks to the District Medical Officer and his staff for their uniform kindness and help and courtesy to the Association during the year, despite all inconveniences. We are also thankful to the District Medical Officer for his case demonstration at our clinical meetings, whenever interesting cases are admitted into the wards. It is hoped the Association will have a habitation of its own early.

The Udipi Branch :—As suggested in the report of the last year, the Executive Committee authorised the Honorary Secretary to organise the

branch in Udipi. Accordingly a meeting of the practitioners in the Coondapoor Revenue Division area was held on 30-4-33, at Udipi, on requisition by the Honorary Secretary who was present at the meeting. The meeting was held on the premises of Dr. P. G. Acharya and under the presidency of Dr. P. Ramachandra Rao one of the oldest practitioners of the place. Dr. V. K. K. Menon, Medical Officer, Udipi, delivered the inaugural address. The branch has been functioning from 1st July.

Conclusion :—The work done during the third year has not been spectacular, but it has been useful and has slowly extended for the improvement of the professional knowledge of its members. The organisation of the Udipi Branch has been an accomplished fact. This will, it is hoped, add to the popularity of the Association. Much remains yet to be done, with the steady co-operation of the members of the profession, the Association will be of greater benefit to the profession and the public

(Sd.) K. R. KINI, M.B & B S.

KODIYALBAIL, P.O., S. K., *15th September 1933.* — *Honorary Secretary.*

APPENDIX I.

Audited Statement of Account for the year ending 36 6-1933.

EXPENDITURE.

				Rs.	A.	P.
To Journals ...				109	15	0
„ Entertainment Account ...				47	2	0
„ Stamps ...				21	15	0
„ Establishment ...				108	0	0
„ Printing and Stationery ...				14	14	6
To Contingent ...				6	12	0
„ V. P. Postage ...				0	10	0
„ Balance C/O.—						
On F. D. Account.	150	0	0			
On S. B. Account.	74	0	0			
On hand.	10	15	7	235	15	0
Total Rs. ...				545	4	3

INCOME.

				Rs.	A.	P.
By Balance—						
On F. D. Account.	60	0	0			
One C. A. at bank.	92	5	0			
Cash on hand.	39	5	7	191	10	0
By Entrance fee current.				7	0	0
„ Subscription.—						
Resident current.	272	0	0			
Add arrears.	50	0	0			
	322	0	0			
Less arrears.	64	0	0	258	0	0
Non-Resident current.	88	0	0			
Add arrears.	54	0	0			
	142	0	0			
Less arrears.	81	0	0	61	0	0
By Entertainment account.				24	0	0
„ Interest ...				3	9	6
Total Rs. ...				545	4	3

Audited and found correct.

(Sd.) U. N. NAYAK,
Honorary Auditor.

(Sd.) K. R. KINI,
Honorary Secretary & Treasurer.

APPENDIX II.

General Meetings held during the year ending 30th June 1933.

23rd July 1932. Lecture on "Leprosy and its treatment with lantern slides" by Dr. Chockalingam, Leprosy Officer, Madras.

20th August 1932. Lecture on "Enlargement of the liver in children" by Dr. K. M. Mathula, L.M. & S.

27th August 1932. Do (Adjourned.)

17th September 1932. Annual General Meeting.

29th October 1932. Lecture on "Recent epedemic of infetious disease" by Dr. K. R. Kini, M B. and B.S.

26th November 1932. Lecture on "Cataract" by Dr. C. P. Kamath, M.B. and B.S.

4th December 1932. Lecture on "Grasto Intestinal Tract by X-Ray diagnosis with lantern slides" by Dr. P. Rama Rao, D M.R, Vienna.

21st January 1933. Lecture on "Cataract and its treatment" by Dr. C. P. Kamath, M.B. and B.S.

25th February 1933. Demonstration of cases in the wards by Dr. K. G. T. Menon, L M. & S (District Medical Officer).

18th March 1933. Lecture on "General convulsions in infants and children" by Dr. U. N. Nayak.

22nd April 1933. Lecture on "Venereal diseases and their treatment" by Dr. U. P. Mallya, L M. & S.

20th May 1933. Lecture on "Salpingitis and its treatment" by Dr. Miss E. Lombardt, M.D.

29th May 1933. Lecture on "Rambles in heart diseases" by Dr. M. L. Kamath, B.A, M D.

28th June 1933. Lecture on "Talepes" by Dr M. S Prabhu M.B.

Proceedings of the Annual General Meeting held on 23rd September 1933 at 5-15 p.m. in the Wenlock Hospital.

Present :—Drs. M. Shiva Rao, K. R. Kini, K. G. T. Menon, K. Vittal Shetty, U. P. Mallya, A. G. Bhat, A. F. Coelho, K. M. Mathullah, N. Upendra Pai, B. G. Acharya, C. P. Kamath, U. S. Nayak, S. S. Hegde, U N. Nayak, K. M. Shenoi, C. Narayan Menon, G. J. Vas, and M. N. Pai.

1. Resolved that the Annual report and Audited statement of accounts be adopted. Proposed by Dr K. Vittal Shetty and seconded by Dr. A. F. Coelho. Passed unanimously.

2. Resolved that the following bye-law No. 19 with the change of addition of the word "collected" at the end of the First clause, as recommended by the Executive Committee :—

"Bye-law No. 19. The Branches of the Association shall pay an annual affiliation fee of 5 per cent of their total annual subscriptions collected. A further 5 per cent of the total annual subscriptions collected shall be paid to the Association, when Journals and library books are supplied to the branch the conveyance to and fro charges being borne by the branch. All payments shall be made Half yearly." From the chair. Passed unanimously.

3. Resolved that the subscriptions from the half year commencing from

1st January 1933, of the non-resident members in the Udipi Branch area be paid to the Udipi branch if collected and all subscriptions prior to 1st January 1933 be collected by the main Association. From the chair. Passed unanimously.

4. Resolved that the budget estimates for the year 1933 34 be adopted. The Executive Committee is requested to find ways and means to improve the permanent fund of the Association, and put forward concrete proposals at a general body meeting within three months. Proposed by Dr. K. Vittal Shetty and seconded by Dr. A. F. Coelho. Passed unanimously

5. Resolved that the President and Honorary Secretary and Treasurer and the members of the Executive Committee of the previous year do continue in office during the present year. Proposed by Dr. K. Vittal Shetty and seconded by Dr. N. Upendra Pai, and supported by Dr. A. F. Coelho. Passed unanimously.

6. Resolved that this meeting of the Association offers its most grateful thanks to the District Medical Officer Dr. K. G. T. Menon for his uniform kindness and courtesy to the members of the Association in their work during the year. Proposed by Dr. K. Vittal Shetty and seconded by Dr. B. G. Acharya. Passed unanimously with acclamation.

The toast of the Association was proposed by Dr. M. S. Prabhu, M.B. & B.S.

8. Resolved that this meeting offers its thanks to Mr. P. Ramakrishnayya, Retired District Registrar, for his presentation of a book "Recent Advances in Medicine" to the Association. From the Honorary Secretary. Passed unanimously.

The toast was replied by Dr. U. P. Mallya, L.M. & S. The President closed the meeting with his closing remarks.

The Honorary Secretary thanked the gathering.

(Sd.) M. SHIVA RAO,
President.

(Sd.) K. R. KINI, M B. & B.S.,
Honorary Secretary and Treasurer.

CORRESPONDENCE

Plasmoquine Dosage.

THE EDITOR,

SIR,

The importers of the French antimalarial remedy Gametoxyl have lately issued an advertisement pamphlet giving the extract of a paper on antimalarial preparations by Dr. E. Charron, Paris. The author compares at the end of his paper Plasmoquine Co. with Gametoxyl, referring particularly to the time of treatment and the amount of medicament required for a complete antimalarial treatment.

In his statement he mentions that *daily dose* of Palasmoquine Co. amounts to 12—16 tablets of the drug and that the total amount of tablets required for a complete treatment lasting 6 weeks is 328 tablets.

Although the above dosage refers to our old discarded tablets containing $\frac{1}{12}$ grain Plasmoquine and $1\frac{1}{4}$ grain quinine sulphate, the dosage circularised among the physicians of British India is *decidedly dangerous*, and we would be greatly obliged if you would issue a warning in your esteemed Journal not to use the dosage mentioned but to stick to the dosage recommended in the authentic medical literature and the official pamphlets

of our firm, who hold themselves responsible for the dosage recommended by them only.

Yours, etc.,
HAVERO TRADING CO., LTD.

The Sad Plight of the Rural Medical Practitioners.

Sir,—The scheme of rural medical relief was introduced by the Government of Madras some eight years ago. Some how or other it has come to stay. Many young medical men entered into this work with enthusiasm but the difficulties they had to face drove some away. But the majority have chosen to carry on in spite of the drawbacks, in the hope that things will improve in course of time.

The Government began by paying Rs. 400 and Rs. 600 by way of subsidies to L. M. Ps and graduates respectively. But later on as a result of the agitation carried on by the Rural Medical Association (thanks to Dr. S. Ramasubbu, the Secretary) the Government increased the same to Rs. 500 and Rs. 700. The increase is not at all adequate.

The Government has provided the rural areas with an efficient scheme of medical relief at the lowest cost. The medical man is to provide his own building, compounder, furniture, surgical equipment, etc., in fact all that goes to make a well equipped dispensary, out of his own pocket. He has to do all the work that a well paid Government service man does. In other words a rural dispensary is a local fund dispensary minus the pay and prospects to the medical man and establishment charges. Now-a-days the villages are too poor to pay the medical men. Some Taluk Boards were helping the above institutions by additional subsidies, house-rent, etc. But now most of the Taluk Boards are in deficit and they have stopped all the extras hitherto paid to their rural medical officers.

Is it therefore any wonder these medical men are discontented?

It is the duty of the Government to improve the lot of these medical men and now that the Government have got a surplus they should come to the rescue of these medical men.

The subsidy must be substantially increased to at least Rs. 800 and Rs. 1,000 so that the medical man may meet the several items of expenditure mentioned above.

The casual leave of 15 days allowed in a year is quite insufficient. They should be given at least 1 month's privilege leave as any other Government servant.

At present there is no scope for a rural medical man to improve his knowledge and keep in touch with the times. He must be given at least 6 months' study leave in any of the recognised premier hospitals, once in 5 years with full pay.

Every rural dispensary must be provided with a midwife by the Government.

Government must sanction long-term loans at a low rate of interest to the medical practitioner to build or purchase a suitable building for the dispensary, payable by instalments.

Lastly I appeal to the rural medical men to organise themselves and agitate.

S. Lalapet, } SRINIVASAN, L.M P.
September 14.

BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.

NOVEMBER 1933.

The Dysenteries : Their Diagnosis and Treatment.*

By Dr. V. Govindarajulu, M.B.B.S.,

Assistant to the Honorary Physician, Government Royapuram Hospital.

"Dysentery" is not the name of a disease but of a symptom complex. It indicates the condition in which there is the passage of frequent stools containing blood and mucus accompanied by pain and tenderness. The etiological factors giving this symptom complex are many, and may be conveniently considered under the following headings:

1. Bacillary,
2. Protozoal,
3. Helminthic, and
4. Psudo-Dysenteries.

Bearing these etiological factors in mind, a complete examination must be made to arrive at the correct diagnosis and formulate the line of treatment. It is very essential to go through the history of the patient to examine every system as in any other disease. It is as essential that the blood and urine of the patient be examined as also the fresh stool. In all cases of dysenteries rectal examination must be done as a routine and, where facilities are available, Sigmoidoscopic examination must be resorted to, to confirm the diagnosis.

Taking the *Bacillary group* first for consideration, the causative organisms are the Bacillus Shiga and those of the Flexner group. The infection is usually acquired by faecal contamination of food and water. Hence it is essential that persons with chronic bacillary dysentery or carriers must not be admitted as cooks. The disease appears in epidemic form after fairs and festivals and in asylums and jails where sanitation is not up to the standard.

The disease is due to the invasion of the mucosa of the large intestine by the specific bacilli and is characterised by pyrexia, symptoms of toxic absorption, and the discharge of blood-stained mucus in the stools. The symptoms may be of any grade of severity, from a mild diarrhœa of several days duration to a fulminating choleraic attack of 2 or 3 days duration.

Duration.—The onset is sudden. There is at first general abdominal discomfort with an initial diarrhœa accompanied by violent and painful intestinal peristalsis. As a rule, the diarrhœa continues for a day or two before the blood appears in the stool. Fever is present in all cases of Bacillary dysentery. Generally it is of low type but in acute attacks the temperature may rise to 103°F or so at night. The fever is intermittent and is accompanied by drowsiness, headache and other symptoms of toxæmia. Generalised griping pain in the abdomen is very characteristic with generalised tenderness over the abdomen. There is marked tenesmus, indicative of the inflammation near the anal orifice, and nearer the anus the site the more severe will be the tenesmus. Early in the disease, the recti muscles are rigid, but, later, especially in fatal cases, the abdomen becomes quite lax and pain is no longer felt, the patient being overwhelmed with toxæmia. In fulminating cases the onset is dramatic; and it is clinically divided into the choleraic

*Read at a Clinical Meeting of the South Indian Medical Union.

and gangrenous types. The choleraic type sets in with vomiting, collapse sets in early and the temperature is subnormal. The tongue is dry and the skin is cold and clammy, the initial diarrhœa being replaced by dark red mucus. The gangrenous type starts with rigor and headache and rapid pulse. The stools early in the disease resembles meat washings, but towards the end become dark-grey offensive fluid, containing much blood. Mucus does not appear in these stools, as the necrosis of the mucosa is extensive and the goblet cells are all destroyed.

The number of motions varies with the severity of the case. In cases taking a favourable course after an initial diarrhœa, the motion consists of gelatinous blood-stained mucus resembling red-current jelly. They are of such tenacity that they adhere to the bed-pan and can be detached only with difficulty. After 3 or 4 days, the stools become more purulent containing less blood. Next bile pigment makes its appearance and, finally the pasty yellow stools indicative of the setting in of convalescence,

Clinically, Bacillary dysentery may be divided into:

1. Mild or catarrhal type (due to infection with the Flexner type).

2. The Choleraic type (due to infection with the Shiga type).

3. Gangrenous type (usually due to infection with the Shiga type).

4. Chronic Bacillary dysentery (usually due to infection with the Flexner type).

In chronic bacillary dysentery, either after an acute or mild catarrhal attack, the stools very often do not become normal for a considerable time and on the slightest indiscretion either of diet or drink the old symptoms reappear. Emaciation of extreme degree and anæmia may develop with dropsy and cardiac failure.

Course.—Death in bacillary dysentery is either due to exhaustion or toxæmia.

Complications :—

1. Arthritis.
2. Peripheral neuritis.
3. Eye complication such as Iridocyclitis.
4. Myocarditis.
5. Pericarditis and endocarditis.
6. Sprue.

Diagnosis is to be made from cholera, ptomaine poisoning, algid type of malaria, and acute type of amoebic dysentery. This may be made by: (1) The examination of the fresh stool in which, microscopically, a preponderance of cellular exudate, macrophage cells, and a few eosinophiles, will be found.

(2) Rectal or Sigmoidoscopic examination. In acute bacillary dysentery the sphincters may be hyper or hypotonic, and the bowel is intensely hyperaemic and instrumentation and rectal examination are painful. With the sigmoidoscope the following points may be made out: The bowel contains a uniform mixture of blood and mucus, and the surface of the mucosa is dull and oedematous. There may be large irregular ulcerated areas which are tender and ooze blood on the slightest touch.

(3) Culture of stools where facilities are available.

(4) Agglutination test in chronic cases.

To wait for culture report is as criminal in cases of Bacillary Dysentery as it is to wait for throat swab culture in cases of Diphtheria.

Treatment.

Treatment—General Management.—Absolute rest in bed is very essential for at least a period of ten days, as the ulcers take at least ten days for complete healing. The patient must be put to bed and the bed pan given. Where the number of stools is very many the best plan would be to discard the bed pan, put the patient in water-proof sheets and pack the buttocks with tow which can be removed when soiled, and burnt. *Warmth* is of prime importance in this disease. This prevents the collapse to a certain extent and protects the patient from chill which may reflexly stimulate intestinal movement and increase the number of motions. Hence hot water bottles to the flank and abdomen are essential.

The diet.—The routine treatment adopted in the Honorary Physician's wards in the Government Royapuram Hospital is to put the patient on whey and albumen water with plenty of warm lime juice and glucose water till the motions are well-formed. But Acton and Knowles in their book on the Dysenteries of India are of opinion that the diet must depend on the infecting organism They are of opinion that in Shiga infection there is the liberation of an exotoxin which is neutralised by the anti-dysenteric serum, an endotoxin on which the specific serum has no action and a pressor base which is extremely toxic, dialysable, diffusible, and not destroyed by heat. It has been shown that these are formed within the gut from the amino-acids of the protein molcule. These bases, which can be isolated, when injected into animals, produce symptoms of acute dysentery with collapse and passage of mucus. But the Flexner group liberates an endotoxin which is not neutralised by the specific serum, forms indol, and not pressor bases with the amino-acids of the portein molecule, ferments many of the sugars with the production of irritating acids. Hence in Shiga infection they advocate solely a carbo-hydrate diet such as warm arrow-root conjee, barley water, glucose water, tea and coffee without milk, to avoid the formation of pressor bases; whereas in Flexner infection the carbo-hydrate diet is contra-indicated, as they produce irritating acids, the patient being put on such articles as meat extract, chicken broth, citrated milk, weak beef, tea and albumin water. The diet should on no account be pushed during convalescence, as the slightest indiscretion may be followed by a relapse.

Specific Treatment.—The polyvalent serum must be adminstered within 48 hours of infection. Doses of 10 c.c. and 20 c.c. ought to be condemned, as they are of little use. To be of use the serum must be administered early in the disease and in large doses, 60 to 80 c c. per dose and repeated if necessary within 24 hours. In acute cases it is better to give the serum intravenously with saline. Before administering serum care must be taken to ascertain whether patient had any serum previously such as anti-tetanic or anti-diphtheritic and there is a family history of asthma, urticaria, etc. In doubtful cases, to avoid anaphylactic reaction it is better to give a desensitizing dose of ½ c.c. subcutaneously 12 hours before the large dose or to start with 5 c.c of the serum well diluted with saline and if no reaction occurs to continue the rest of the. dose. Here again Acton and Knowles are of opinion that serum treatment in Flexner infection is of very limited use as the Flexner group produces only an endo-

toxin on which the specific serum has very little action.

The medical treatment aims at relieving the congestion of the mucosa and getting rid of the toxin from the intestinal canal. The following mixture is usually given :

Sodi Sulph gr. 60.
Acid Sulph dil m. 15.
Tinct. ginger m. 10.
Aqua 1 ounce.

This dose is administered every 4 hrs. till the motion becomes faeculant, when it may be given 6th hourly and then 8th hourly. A few patients do not tolerate this saline treatment. In these cases the patient is put on drachm doses of Bismuthi oxy-carbonatis suspended in a little water till the stools become black, when the prognosis is reassuring. Warm bowel wash is of distinct value in these cases. Some prefer permanganate of potash on the belief that the oxygen of the permanganate may neutralise the toxin. Others are of opinion that the action is more mechanical and hence prefer a boric wash. If the tenesmus is very severe and the patient sleepless, tincture of opium enema or morphia subcutaneously may be of distinct value. Collapse may be guarded against by keeping the patient warm and giving such stimulants as brandy either by mouth or rectum. In cases of collapse intravenous saline must be administered in generous quantity, and in the choleraic type of cases Roger's hypertonic saline is advocated. Vomiting and hiccup are of serious omen, and, if they set in, adrenalin by mouth and turpentine stupes are of distinct value. Bacillary dysentery occurring in pregnant women is liable to bring about miscarriage and in such patients the dose of the saline aperient must be reduced or replaced by bismuth.

Bacteriophage Treatment was tried with success in one case recently. The patient was admitted on the 4th day of infection with history of 20 30 motions. The temperature was 102°F and generalised tenderness all over the abdomen was present. The motion was mucopurulent and full of cellular exudate and macrophage cells The patient was treated on the usual line but as the infection was of more than 48 hours duration Bacteriophage Treatment was resorted to, 2 c.c. of the phage being given orally every 4th hour with 2 ounces of water. The stools became normal on the second day of treatment and their number came down to 2 on the 3rd day, the patient becoming free from Dysenteric symptoms the same day. Acton and Knowles also are of opinion that this is a very promising line of treatment, everything depending on the right strain of phage.

[The Bacteriophage treatment for dysenteries has not given very useful results in the hands of the great majority of workers — ED]

After-treatment.—The chief complication during convalescence in these cases is constipation. This must be guarded against by giving mild laxatives, such as liquid paraffin. If this is not guarded against the ulcers may not heal properly as the hard faecal matter may irritate the healing ulcers.

Treatment of Chronic cases—Rest is as essential as in the acute cases. The patient must be on good nourishing food. As serum treatment is of no use, bacteriophage treatment may be tried. Wherever possible autovaccine may be made and tried, the initial dose being 5 millions gradually increasing up to 50 millions, the injection being given bi-weekly. It is extremely difficult to isolate the Dysenteric organisms in these cases as the organism has often disappeared or has been replaced by secondary invaders such as Bacillus Pyocyaneous

or Bacillus meta-dysenterica. In such cases it is advised to culture these secondary invaders and test the patient's serum for agglutination against these secondary invaders to find out their pathogenic role. If this is positive the stock vaccine of the primary dysentery bacilli may be added to the auto-vaccine of the secondary invaders and the patient treated. The efficacy of rectal irrigation is much disputed. Manson Bahr advocated colonic irrigation. For this the bowel is cleaned up by a previous dose of castor oil. An enema is given just before starting the irrigation. The patient is put in the knee-elbow position, or the left lateral position, and the rectal tube is pushed gently for a distance of 3 inches and the irrigation started. Non-irritating lotions such as boric is preferred (or soda bicarb. 3-4 drachms to normal saline) and the fluid is run in gradually, the whole process taking nearly an hour. The funnel is on no account raised for more than a height of 2 feet. When this is not successful, surgical measures such as appendicostomy, cæcostomy or colostomy, for allowing the faecal matter to pass through the tube, and daily irrigation of the lower bowel may be resorted to.

Acton and Knowles advocate iodine either by mouth or intravenously as an adjuvant to the above line of treatment. They are of opinion that in these cases the intake of iodine is less and hence there is a condition of hypo-thyroidisim. Following the same line of reasoning they argue that Scott's plan of administering calcium and parathyroid will do good in some cases. In neurasthenic cases endocrine therapy is advocated.

The Protozoal.—The organisms giving rise to dysentery are the following:

1. Entamoeba histolytica.
2. Plasmodium falciparum.
3. Leishmania donovani.
4. Balantidium coli.

Amaebic Dysentery is due to invasion of the mucus membrane of the gut by Entamoeba histolytica. The infection is acquired by swallowing the cysts of the parasite. These cysts are very resistant. Yorks and Adams are of opinion that normal stools contain a substance which tend to kill the cysts, but when the faeces are diluted with water these are said to survive up to a period of three weeks. They are remarkably resistant to Emetine and insoluble in gastric juice but soluble in Trypsin. Hence when swallowed they pass through the stomach unchanged and excyst in the small or large intestine. It is said that each cyst emerges out as an amoeba with four nuclei, which by binary fission soon divide into four separate amoeba. The vegetative form soon reaches the submucus tissue, which is their habitat, either through the crypts of Leiberkuhn or directly. They secrete a powerful proteolytic ferment and feed upon the perished tissue juice and on the red blood corpuscles.

The incidence of Amoebic dysentery is now known to be world wide. Dobell (1921) examined 3,146 persons in the United Kingdom and found 10 per cent to be amoebetised. Bock and Stills (1923) examined 8,029 cases in America and gives the figure as 8 to 10 per cent, and it is the opinion of Acton and Knowles that in the tropics at least 15 per cent of human being is parasitized with amoeba. The infection when once acquired persists in most untreated cases for the rest of life. Why infection should give rise to dysenteric symptoms in a few and not in others is not definitely known. It is believed that lowering of

resistance and the presence of haemolytic streptococci are responsible to a certain extent.

Spread.—The disease is spread by the carrier, the house fly, by the eating of contaminated food, drink, and raw vegetables.

The incubation period is indefinite and on the average is said to be 20-90 days.

The onset.—The mode of onset of amoebic dysentery is quite different from that of the bacillary dysentery. The onset is insiduous, fever is absent except in acute cases and in mixed types. The symptoms of toxæmia are lacking. The patient may complain of diarrhœa which in course of days may lead to dysenteric symptoms. One must not judge the condition by the clinical picture, for cases have been reported where, though the patient has not reported much of dysenteric symptoms, yet perforation has lead to fatal peritonitis. No age is exempt from the disease.

Clinically amoebic dysentery may be divided into four types :

(1) *The Acute Type.*—Tenderness is marked over the transverse colon and the flexures as opposed to the generalised tenderness of Bacillary dysentery. The number of stools may be many but never exceed 20. Straining and tenesmus are usually less than bacillary form, as the rectum and the lower portion of the gut are less frequently involved. In this type the character of the stool is seldom sufficiently distinctive to enable it to be recognised by the naked eye inspection. In severe cases they are full of cobweb-like slough. Megaw is of opinion that the appearance of the washed stools give valuable diagnostic and prognostic indication. The stool is washed by pouring water over the whole stool and allowing it to stand for a short time, to allow the mucus and slough to settle when the surface water with most of the faecal matter can be decanted; this process is repeated until all the faecal matter is got rid of. He describes that a black slough, resembling a mass of old cobweb as evidence of dangerous gangrene, pus infiltrated slough as of good prognostic indication, gelatinous mucus as an indication of early stage of the disease, and abundant ropy mucus as an indication of approaching recovery. Death may be due to exhaustion, intestinal haemorrhage, perforation and peritonitis, or complicating liver abscess.

(2) *The Chronic Type.*—This may follow an acute attack owing to neglect or may begin insidiously. The number of motions varies greatly the patient complaining more of diarrhoea than of dysentery. In this class of cases, fever is absent unless complicated with hepatitis. The patient is very anaemic and emaciated. Blood may show relative leucocytosis with relative mononucleosis. Careful examination of the abdomen usually reveals some thickening and tenderness of the large bowel, especially in the right iliac fossa, which may be mistaken for tubercular caecum.

(3) *The Latent Type.*—Very few cases are diagnosed as such. Yet postmortem amoebic ulceration of the gut has been noticed in patients who gave no history of dysentery in their lifetime. These patients may develop liver abscess at any time.

(4) *The Mixed Type.*—Mixed infection of both amoebic and bacillary dysentery is quite common in our hospital cases. Fletcher and Jepps (1924) recorded 27 out of their series of 198 cases or 14 per cent. as of this variety. In the opinion of some, amoebic infection superimposed on bacillary infection is rare, but it is

more common for acute bacillary dysentery to supervene on an intestine which is in a condition of chronic amoebic ulceration.

Complications—The most common complication is liver abscess. Alcoholic excess is said to predispose to this affection. In the course of the ulceration the amoebae enter one of the radicals of the portal vein and are carried to the liver where they give rise to abscess formation. In this connection it may be mentioned that these amoebae may even enter the systemic circulation and give rise to abscess in any organ. Cases are reported of amoebic abscess of the brain, lungs, spleen, testes, epidydimis, etc Other complications are (1) Localised peritonitis and adhesion between the coils of the intestines; (2) Perforation and fatal peritonitis; (3) Fatal intestinal hæmorrhage; (4) Cirrhosis of the liver.

Diagnosis.—Amoebic dysentery must be differentiated from the other types of dysentery. The following points are worth remembering in differentiating this disease from the bacillary type.

		Amoebic Dysentery.	*Bacillary Dysentery.*
1	Onset.	Insidious.	Sudden.
2.	Pyrexia.	Rare.	Very common.
3.	Toxaemia.	Slight.	Marked.
4.	Course.	Long	Short and sharp.
5.	Tenesmus.	Not much unless the ulcers are near the rectum.	Very severe, the patient is, so to say, glued to the commode.
6.	Agglutination test.	Negative.	Positive in chronic cases, where the duration has been more than 2 weeks.

The following are the differences, microscopic and macroscopic, between the stools of amoebic and bacillary dysentery.

		Amoebic	*Bacillary.*
1.	Quantity and appearance.	Large, faecal matter mixed with mucus.	Scarcely little of faecal matter; bright blood; red gelatinous and gummy.
2.	Odour.	Very offensive, smelling of decomposed blood.	Odourless as a rule.
3.	Reaction to litmus.	Acid.	Alkaline.
4.	Red blood corpuscle.	Shrunken, dark brown, and agglutinated. Acton and Knowles lay much stress on this point and say that its presence with cellular exudate is definitely indicative of mixed type of dysentery.	Unchanged.
5.	Cellular exudate.	Few, the leucocytes have ant-eaten appearance.	Plenty with clean cut nuclei.
6.	Macrophage cells.	Not found.	Plenty.
7.	Entamoeba histolytica.	Found.	Not found.
8.	Other organisms.	Present.	Not found.
9.	Charcot-heyden crystals.	Found.	Not found.

For examination of the stool it is very essential that the motion must be fresh, free from urine and antiseptic, and passed into a dry bed-pan. A useful method of obtaining fresh motion for examination is that suggested by Proctor. Pass a rubber catheter well into the rectum, twist round several times and withdraw. There will be enough material in the eye of the catheter for the examination. The specimen may be examined under the microscope in one of the following ways:

(1) as it is, on a clean slide, with a clean cover slip, selecting the mucus portion, for examination under 1/6 power of the microscope ;

(2) or make an emulsion of the mucus with 0·85% saline and examine ;

(3) or in Iodine emulsion of the following strength : 1 gram of Iodine dissolved with 2 grams of Pot. iodide in water to make up 100 c.c. The solution must be fresh. By this method the cysts are well stained.

Treatment.—In spite of the number of supposed *specifics* pouring into the market daily, Ipecacuanha and its alkaloid Emetine still holds the field. Before the introduction of Emetine, Ipecacuanha was given in drachm doses.

To avoid the emetic action, the drug was used to be given on an empty stomach after the administration of Tinct. opii 15 to 20 m. with the additional precaution of a counter irritant to the pit of the stomach. Thanks to the introduction of Emetine no such tedious precautions are required now. The alkaloid is given in grain doses daily subcutaneously or intravenously, depending on the gravity of the case. The exact action of Emetine on Entamoeba hystolytica is still a disputed point. Sir Leonard Rodgers was the first to introduce the drug. He is of the opinion that the drug has some direct action on the parasite. But Wenyon (1926) pointed out that active Entamoeba histolytica, either in faeces or in liver abscess pus, mixed with a strong solution of Emetine, was as active as in the control. It has been argued against this that the Emetine has been fixed up by the pus or faecal matter and had no action on the amoeba. Dale and Dobell are of opinion that the primary action of Emetine was apparently on the host in some way rendering the tissue unsuitable for the amoeba. But Sellards and deLevara have shown that administering a solution of Emetine per rectum in the case of a kitten infected with amoebae killed the parasite. In view of the work of Dobell and Laidlaw (1926), it is concluded that in human beings Emetine has a direct action against Entamoeba.

Care must be taken in the use of Emetine. Heroic doses and continuation of the drug for more than a period of 12 days is not advisable. It must be given in courses with intervals to avoid the cumulative action of the drug. In excessive doses emetine may produce the following symptoms :

1. Asthenia.
2. Cardiac irregularity.
3. Low blood pressure.
4. Emaciation and loose yellow motion.
5. Mental depression.
6. Neuritis of certain groups of mucles especially of the extremities.
7. Atrophic condition of the nails.

The treatment adopted in cases of amoebic dysentery in the Honorary Physician's Wards, Government Royapuram Hospital, is as follows :—

1. Absolute rest in bed.

2. Diet, only conjees made with such substances as Sago, Arrowroot, and Barley.

3. Emetine grain 1 daily, subcutaneously for a period of 6 days; Mist olei ricini, ℥ 1, every 6th hour till the motion is well-formed, when it is replaced by Mist Bismuthi Sedative (General Hospital Pharmacopoea.) The patient is discharged (usually for want of beds with the advice to come

for another course of six injections of emetine. In cases where the number of stools is large or where the patient complains of much pain, starch and opium enema is given for a day or two.

Acton and Knowles advocate the following line of treatment.

To start with, a full dose of saline aperient to flush out the colon ; next day the patient is put on Bismuthi oxy-carbonate in drachm doses and Emetine gr. 1 is given subcutaneously. They attribute that bismuth alters the reaction of the intestinal contents and increases the amoebicidal action of Emetine. To get the maximum effect of Emetine they say that the injection of Emetine is to be given 2½ hours after the first dose of Bismuth. This treatment is continued for a period of 9 days. An interval of 3 days, followed by a second course for 6 days is instituted.

The injection of Emetine alone is not sufficient to eradicate the infection as Emetine has no action on the cysts. For this purpose a number of drugs are recommended and the following are supposed to be effective.

1. Bismuth Emetine Iodide ; Emetine per-iodide Dose 1 grain, in gelatine capsules, three times a day for 12 days. The drug causes vomiting and diarrhoea in the early stages, indicative of the absorption of the drug. Many observers report favourably with these drugs. Megaw is of opinion that the violent purgative action of the drug is an important factor in getting rid of the infection.

2. Stovarsol. Knowles reports favourably on this drug. It is given in pill form, 4 gr. being given 3 times daily. It is advised not to give this drug for more than a week at a time as it has a tendency to induce severe dermatitis on account of the Arsenic in it.

3 Yatren-105 in dose of 4 pills three times a day for a week.

4. Kurchi Bark and its derivatives. Acton and Knowles report favourably on this drug but deplore the want of standardised preparation of it. The drug is easily available in India. It is well tolerated by mouth, and in experimental work appears to be actively amoebicidal.

Now passing on to the non-amoebic types of protozoal dysentery one by one the malarial, especially the sub-tertian, parasite, when in the mesenteric veins give rise to dysenteric symptoms due to haemorrage into the intestine. Diagnosis is to be made by the routine examination of the blood. Instances have been reported in which malaria was suspected from the discovery of the parasite within the R B. C. in the stool. The temperature is always raised and this together with the icteric condition of the skin and enlarged spleen should suggest malaria.

Leishman Donavan body.—It was formerly thought that Leishman-Donavan bodies produce ulceration of the intestine and gave rise to dysenteric symptoms in the later stages of Kala-Azar. The present day opinion is that these are due to super-added infection either of bacillary or amoebic type. So in all cases of Kala-Azar showing dysenteric symptoms the stool must be examined as a routine.

Balantoidal Dysentery.—This is very rare in India and is said to be common in France and Germany. Those who tend domestic pigs are exceptionally liable. Examination of the motion reveals the parasite.

Treatment.—Organic silver compounds are supposed to be specific. Thymol is recommended by some.

Methylene-blue, internally and by irrigation, is recommended by others.

Helminthic Group.—The chief of these being Schistosomiasis Mansonicum and Japonicum The former is endemic in South America and Egypt and the latter in Japan and the Philippine Islands. Ascariasis in children and Hookworm in adults may occasionally produce symptoms of dysentery.

Diagnosis.—Examination of the motion and rectal examination for polypus in the cases of Schistosomiasis together with a history of having been in the endemic area will clear the diagnosis.

Treatment.—Injection of tartar emetic and other antimonial preparations is said to be specific.

Psudo-Dysentery.—As the name suggests, is not due to any definite infection. The rectal examination and sigmoidoscopic examination are very essential for ɔer diagnosis of these cases. They are due to

(1) Internal haemorroids and inflamed piles.

(2) Polypus of the rectum, including malignant growths.

(3) Syphilitic infection of the sigmoid flexure and rectum during the tertiary stage.

(4) Intersusception, especially in children.

(5) Chronic mercurial poisoning.

(6) Proctitis due to foreign bodies.

(7) Tubercular infection of the caecum or sigmoid.

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